		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041715

Facility Name: Countryview Terrace

Address: R.R. Box 195 (Number) Louisville (City) 62858 (Zip Code)

County: Clay

Telephone Number: (618) 686-4542 **Fax #** (618) 686-2179

IDPA ID Number: 371346306

Date of Initial License for Current Owners: 02/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,812			5,812	13
14	TOTALS	5,812			5,812	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.52%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	22,526	1,437	317	24,280		24,280		24,280			1
2	Food Purchase		18,077		18,077		18,077		18,077			2
3	Housekeeping		2,061		2,061		2,061		2,061			3
4	Laundry		456		456		456		456			4
5	Heat and Other Utilities			9,020	9,020		9,020	98	9,118			5
6	Maintenance	6,761	6,535	1,203	14,499		14,499	174	14,673			6
7	Other (specify):*											7
8	**TOTAL General Services**	29,287	28,566	10,540	68,393		68,393	272	68,665			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	109,749	2,355	579	112,683		112,683		112,683			10
10a	Therapy											10a
11	Activities		262	113	375		375		375			11
12	Social Services	18,276	37	1,733	20,046		20,046		20,046			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	128,025	2,654	5,725	136,404		136,404		136,404			16
	C. General Administration											
17	Administrative	53,515		16,053	69,568		69,568	(16,053)	53,515			17
18	Directors Fees											18
19	Professional Services			9,949	9,949		9,949	2,140	12,089			19
20	Dues, Fees, Subscriptions & Promotions			828	828		828	131	959			20
21	Clerical & General Office Expenses	6,117	942	6,563	13,622		13,622	2,777	16,399			21
22	Employee Benefits & Payroll Taxes			36,894	36,894		36,894	3,350	40,244			22
23	Inservice Training & Education							109	109			23
24	Travel and Seminar			78	78		78	274	352			24
25	Other Admin. Staff Transportation			2,381	2,381		2,381	257	2,638			25
26	Insurance-Prop.Liab.Malpractice			9,360	9,360		9,360	394	9,754			26
27	Other (specify):*											27
28	**TOTAL General Administration**	59,632	942	82,106	142,680		142,680	(6,621)	136,059			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	216,944	32,162	98,371	347,477		347,477	(6,349)	341,128			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Countryview Terrace #0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			20,899	20,899		20,899	3,640	24,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,210	32,210		32,210	1,508	33,718			32
33	Real Estate Taxes			4,575	4,575		4,575	(35)	4,540			33
34	Rent-Facility & Grounds							585	585			34
35	Rent-Equipment & Vehicles							89	89			35
36	Other (specify):*											36
37	**TOTAL Ownership**			57,684	57,684		57,684	5,787	63,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,061	30,061		30,061		30,061			42
43	Other (specify):* Nonallowable Costs			328	328		328	(328)				43
44	**TOTAL Special Cost Centers**			30,389	30,389		30,389	(328)	30,061			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	216,944	32,162	186,444	435,550		435,550	(890)	434,660			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(275)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,137	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(35)	33		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(53)	43		28
29	Other-Attach Schedule Miscellaneous Income	(160)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,614		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,504)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,504)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (890)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace

ID# 0041715

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Terrace **#** 0041715 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	98	0	0	0	0	0	0	0	0	0	98	5
6	Maintenance	0	174	0	0	0	0	0	0	0	0	0	174	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	272	0	0	0	0	0	0	0	0	0	272	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(16,053)	0	0	0	0	0	0	0	0	0	(16,053)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,140	0	0	0	0	0	0	0	0	0	2,140	19
20	Fees, Subscriptions & Promotions	0	131	0	0	0	0	0	0	0	0	0	131	20
21	Clerical & General Office Expenses	0	2,937	0	0	0	0	0	0	0	0	0	2,937	21
22	Employee Benefits & Payroll Taxes	0	3,350	0	0	0	0	0	0	0	0	0	3,350	22
23	Inservice Training & Education	0	109	0	0	0	0	0	0	0	0	0	109	23
24	Travel and Seminar	0	274	0	0	0	0	0	0	0	0	0	274	24
25	Other Admin. Staff Transportation	0	257	0	0	0	0	0	0	0	0	0	257	25
26	Insurance-Prop.Liab.Malpractice	0	394	0	0	0	0	0	0	0	0	0	394	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(6,461)	0	0	0	0	0	0	0	0	0	(6,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(6,189)	0	0	0	0	0	0	0	0	0	(6,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Terrace # 0041715 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,137	1,503	0	0	0	0	0	0	0	0	0	3,640	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,508	0	0	0	0	0	0	0	0	0	1,508	32
33	Real Estate Taxes	(35)	0	0	0	0	0	0	0	0	0	0	(35)	33
34	Rent-Facility & Grounds	0	0	585	0	0	0	0	0	0	0	0	585	34
35	Rent-Equipment & Vehicles	0	0	89	0	0	0	0	0	0	0	0	89	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,102	3,011	674	0	0	0	0	0	0	0	0	5,787	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(328)	0	0	0	0	0	0	0	0	0	0	(328)	43
44	**TOTAL Special Cost Centers**	(328)	0	0	0	0	0	0	0	0	0	0	(328)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,774	(3,178)	674	0	0	0	0	0	0	0	0	(730)	45

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen						
Mark Petersen	See Attached Schedule 6A			See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Petersen Health Care Companies	0.00%	$ 98	$ 98	1
2	V	6	Maintenance		Petersen Health Care Companies	0.00%	174	174	2
3	V	17	Administrative	16,053	Petersen Health Care Companies	0.00%		(16,053)	3
4	V	19	Professional Services		Petersen Health Care Companies	0.00%	2,140	2,140	4
5	V	20	Dues, Fees, & Subscriptions		Petersen Health Care Companies	0.00%	131	131	5
6	V	21	Clerical & General Office		Petersen Health Care Companies	0.00%	2,937	2,937	6
7	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	3,350	3,350	7
8	V	23	Inservice Training		Petersen Health Care Companies	0.00%	109	109	8
9	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	274	274	9
10	V	25	Other Admin Staff Transport.		Petersen Health Care Companies	0.00%	257	257	10
11	V	26	Insurance		Petersen Health Care Companies	0.00%	394	394	11
12	V	30	Depreciation		Petersen Health Care Companies	0.00%	1,503	1,503	12
13	V	32	Interest		Petersen Health Care Companies	0.00%	1,508	1,508	13
14	Total			$ 16,053			$ 12,875	$ * (3,178)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider # 0041715
12/31/2002

Schedule 6A

VII Related Parties-Page 6

Related Nursing Homes	City
Robings Manor Nursing Home	Brighton, IL
Bement Health Care Center	Bement, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie City Health Care Center *	Prairie City, IL
Out of State Nursing Homes	
Meadow Lawn Nursing Center	Davenport, IA
Friendly Village *	Rhinelander, WI
Horizons Unlimited *	Rhinelander, WI
Taylor Park *	Rhinelander, WI
Passport *	Rhinelander, WI
Cumberland Heights-Tomahawk *	Tomahawk, WI
Maple Park *	Rhinelander, WI
Opportunities Unlimited (Workshop setup, no beds)	
Other Related Business Entities	
Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor
Related Assisted Living Facilities	
Courtyard Estates	Kewanee, IL

* Not affiliated after 08/30/02.

Ownership Percentages:	01/01/02 - 08/30/02	08/31/02 - 12/31/02
James Petersen	60.00%	0.00%
Mark Petersen	40.00%	100.00%

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		34	Rent-Facility & Grounds	$	Petersen Health Care Companies	0.00%	$ 585	$ 585	15
16	V		35	Rent-Equipment & Vehicles		Petersen Health Care Companies	0.00%	89	89	16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 674	$ * 674	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	Ex - President	Administrative	Sch. 6A	326,513	1	2.50	Salary	$ 8,487	L17, C1	1
2	Mark Petersen	President	Administrative	Sch. 6A	121,834	1	2.50	Salary	3,166	L17, C1	2
3	Mark Petersen	Administrative	Administrative	Sch. 6A	122,808	1	2.50	Salary	3,192	L17, C1	3
4	Todd Petersen	Administrative	Administrative	0.00	66,318	1	2.50	Salary	1,724	L21, C1	4
5											5
6											6
7		See Attached Schedule 7A									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,569		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Countryview Terrace
Provider # 00041715
12/31/2002

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Havana Care Center	Prairie City	Arcola Health Care	Kewanee Care Center	Palm Terrace of Mattoon	Bement Health Care	Eastview Terrace	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Total	Country View Terrace	Grand Total
James Petersen	40,847	8,796	50,451	39,308	5,410	29,605	29,671	33,470	34,462	54,493	326,513	8,487	335,000
Mark Petersen	15,242	3,282	18,825	14,668	2,018	11,047	11,071	12,489	12,859	20,333	121,834	3,166	125,000
Mark Petersen - Administrative	15,363	3,308	18,976	14,785	2,034	11,135	11,160	12,589	12,962	20,496	122,808	3,192	126,000
Todd Petersen	8,297	1,787	10,247	7,984	1,097	6,013	6,027	6,798	7,000	11,068	66,318	1,724	68,042
Total Compensation Received From Other Nursing Homes	79,749	17,173	98,499	76,745	10,559	57,800	57,929	65,346	67,283	106,390	637,473	16,569	654,042

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	$ 3,858	$	5,812	$ 98	1
2	6	Maintenance	Patient Days	229,422	11	6,877		5,812	174	2
3	19	Professional Services	Patient Days	229,422	11	84,471		5,812	2,140	3
4	20	Dues, Fees & Subscriptions	Patient Days	229,422	11	5,163		5,812	131	4
5	21	Clerical & General Office	Patient Days	229,422	11	115,931		5,812	2,937	5
6	22	Employee Benefits	Patient Days	229,422	11	132,243		5,812	3,350	6
7	23	Inservice Training	Patient Days	229,422	11	4,287		5,812	109	7
8	24	Travel & Seminar	Patient Days	229,422	11	10,813		5,812	274	8
9	25	Other Admin Staff Transport.	Patient Days	229,422	11	10,154		5,812	257	9
10	26	Insurance	Patient Days	229,422	11	15,558		5,812	394	10
11	30	Depreciation	Patient Days	229,422	11	59,343		5,812	1,503	11
12	32	Interest	Patient Days	229,422	11	59,511		5,812	1,508	12
13	34	Rent-Facility & Grounds	Patient Days	229,422	11	23,100		5,812	585	13
14	35	Rent-Equipment & Vehicles	Patient Days	229,422	11	3,511		5,812	89	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 534,820	$		$ 13,549	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	649 plus int.	08/31/02	$ 479,263	$ 476,668	08/31/07	Varies	$ 30,382	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Nick Adkins Brokerage		X	Commission Note	$284.00	09/10/96	225,000	10,479	08/10/06	0.0900	1,021	6
7	LaSalle Bank		X	Line of Credit	Interest Only	08/31/02	54,387	54,387	08/31/03	Varies	807	7
8												8
9	TOTAL Facility Related				$284.00		$ 758,650	$ 541,534			$ 32,210	9
	B. Non-Facility Related*											
10												10
11	Allocated From Home Office										1,508	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,508	14
15	TOTALS (line 9+line14)						$ 758,650	$ 541,534			$ 33,718	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 4,508	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 4,508	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,540	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 4,540	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	3,988	8
	1998	4,260	9
	1999	4,361	10
	2000	4,508	11
	2001	4,508	12

	FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2001	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

2001 Tax Bill:	4,508
Est. Increase:	32
Est. Accrual:	4,540

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0041715

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-100-030	SEC 15-5-6-PT SE NW S&W of	$ 4,508.00	$ 4,508.00
2.		OLD US 45 - 7.63 AC	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,508.00	$ 4,508.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	402,930	1996	$ 10,000	1
2					2
3	TOTALS	402,930		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1996	1976	$ 579,889	$ 14,869	35	$ 16,568	$ 1,699	$ 115,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Survey			1996	1,700		20	85	85	567	9
10	Curtains			1996	307	27	20	15	(12)	98	10
11	Pump Repairs			1996	1,163		20	58	58	392	11
12	Repiping Water Heater			1996	1,681		20	84	84	553	12
13	Fence			1997	2,469	149	20	123	(26)	646	13
14	Plumbing			1997	1,234		20	62	62	351	14
15	Handicapped Showers & Ramp			1998	1,962	50	20	98	48	441	15
16	Landscaping			2000	4,289	367	20	214	(153)	535	16
17	Drainage and Sidewalk			2001	2,557	66	20	128	62	192	17
18	Roof			2001	8,702	223	20	435	212	653	18
19	Water Supply			2002	2,412	49	20	121	72	121	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 608,365	$ 15,800		$ 17,992	$ 2,192	$ 120,400	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 37,688	$ 3,474	$ 3,769	$ 295	10	$ 23,217	71
72	Current Year Purchases	552	221	28	(193)	10	28	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			1,503	1,503	Various		74
75	TOTALS	$ 38,240	$ 3,695	$ 5,300	$ 1,605		$ 23,245	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van	1995 Dodge Maxivan	1999	$ 9,986	$ 1,404	$ 1,248	$ (156)	5	$ 4,992	76
77										77
78										78
79										79
80	TOTALS			$ 9,986	$ 1,404	$ 1,248	$ (156)		$ 4,992	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 666,591	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,899	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,539	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,640	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 148,637	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocated from Home Office			585			5
6								6
7	TOTAL				$ 585 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 89 Description: Allocated from Home Office $89
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,716	$ 10,716	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	82,089	82,089	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,991	16,991	6
7	Other Prepaid Expenses	390	390	7
8	Accounts Receivable (owners or related parties)	116,121	116,121	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 226,307	$ 226,307	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	600,118	608,365	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	48,226	48,226	16
17	Accumulated Depreciation (book methods)	(145,678)	(148,637)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 516,835	$ 517,954	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 743,142	$ 744,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,879	$ 35,879	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	54,387	54,387	29
30	Accrued Salaries Payable	8,483	8,483	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,540	4,540	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	12,458	12,458	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 115,747	$ 115,747	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,479	10,479	39
40	Mortgage Payable	476,668	476,668	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 487,147	$ 487,147	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 602,894	$ 602,894	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 140,248	$ 141,367	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 743,142	$ 744,261	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

FACILITY NAME Countryview Terrace
PROVIDER # 00041715
12/31/2002

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Assessments	(781)	(781)
Accrued Interest	54	54
Accrued General Insurance	12,233	12,233
Accrued Workers Comp. Insurance	663	663
Accrued Other Expenses	289	289
Total Line 36 - Other Current Liabilities(specify):	**12,458**	**12,458**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 130,094	1	
2	Restatements (describe):		2	
3	Rounding	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 130,095	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	85,153	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(75,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 10,153	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 140,248	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 518,213	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 518,213	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See Attached Schedule 19A**	2,490	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,490	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 520,703	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	68,393	31
32	Health Care	136,404	32
33	General Administration	142,680	33
	B. Capital Expense		
34	Ownership	57,684	34
	C. Ancillary Expense		
35	Special Cost Centers	328	35
36	Provider Participation Fee	30,061	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 435,550	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,153	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,153	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a Cash Basis Taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

FACILITY NAME Countryview Terrace
PROVIDER # 0041715
12/31/2002

XVII. INCOME STATEMENT

Schedule 19A

	Before Consolidation
Transportation Income	2,330
Miscellaneous Income	160
Total	**2,490**

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	13,504	13,880	109,749	7.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	18,276	8.79	11
12	Dietician					12
13	Food Service Supervisor	2,183	2,239	22,526	10.06	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	717	717	6,761	9.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,111	2,111	41,862	19.83	20
21	Assistant Administrator					21
22	Other Administrative	53	53	11,653	219.87	22
23	Office Manager					23
24	Clerical	328	329	6,117	18.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,976	21,409	$ 216,944 *	$ 10.13	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	2 Visits	$ 317	L1, C3	35
36	Medical Director	Monthly	3,300	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	11	324	L10, C3	38
39	Pharmacist Consultant	9 Visits	255	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	113	L11, C3	44
45	Social Service Consultant	4	113	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	8	1,620	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	27	$ 6,042		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miranda Wattles	Administrator	0%	$ 38,670
Mark Petersen	Administrative	*	3,166
Allocated From Home Office			
James Petersen	Administrative	*	8,487
Mark Petersen	Administrative	*	3,192
* See Attached Schedule 6A			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,515

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Column 7)	$ 16,053
TOTAL (agree to Schedule V, line 17, col. 3)	$ 16,053
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 3,305
America On Line	Computer Services	299
Sam's Club	Computer Services	97
Ginoli & Co.	Accounting	2,548
Altschuler, Melvoin & Glasser LLP	Accounting	3,700
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,949

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,615
Unemployment Compensation Insurance	2,365
FICA Taxes	13,920
Employee Health Insurance	13,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,578
401(k) Fee	268
Allocated from Management Company	3,350
TOTAL (agree to Schedule V, line 22, col.8)	$ 40,244

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care Association	208
Various Licenses & Permits	220
Allocated From Management Company	131
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 959

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	78
Seminar Expense	
Allocated from Management Company	274
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 352

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider #: 0041715
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,949
Allocated from Management Company	
Legal	209
Accounting	1,931
Total (agree to Schedule V, line 19, column 8)	12,089

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0041715 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0041715 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $208**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **30,061**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Countryview Terrace** **02:35 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-890	equal to	-890	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	33,718	equal to	33,718	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	4,540	equal to	4,540	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	24,539	equal to	24,539	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	585	equal to	585	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	89	equal to	89	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	68,393	equal to	68,393	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	136,404	equal to	136,404	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	142,680	equal to	142,680	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	57,684	equal to	57,684	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	328	equal to	328	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	30,061	equal to	30,061	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	109,749	equal to	109,749	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	18,276	equal to	18,276	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	22,526	equal to	22,526	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	6,761	equal to	6,761	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	53,515	equal to	53,515	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	6,117	equal to	6,117	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	216,944	equal to	216,944	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	317	< or = to	317	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,300	< or = to	3,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	579	< or = to	579	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	113	< or = to	113	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	113	< or = to	1,733	-1,620	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	53,515	equal to	53,515	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	16,053	equal to	16,053	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,949	equal to	9,949	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	40,244	equal to	40,244	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	959	equal to	959	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	352	equal to	352	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	30,061	equal to	30,061	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	3,350	-3,350	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-2,504	equal to	-2,504	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	541,534	equal to	541,534	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	4,540	equal to	4,540	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	608,365	equal to	608,365	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	48,226	equal to	48,226	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	148,637	equal to	148,637	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	140,248	equal to	140,248	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	85,153	equal to	85,153	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	743,142	equal to	743,142	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		22,526	1,437	317	24,280	0	24,280	0	24,280
2. Food Purchase		0	18,077	0	18,077	0	18,077	0	18,077
3. Housekeeping		0	2,061	0	2,061	0	2,061	0	2,061
4. Laundry		0	456	0	456	0	456	0	456
5. Heat and Other Utilities		0	0	9,020	9,020	0	9,020	98	9,118
6. Maintenance		6,761	6,535	1,203	14,499	0	14,499	174	14,673
7. Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		29,287	28,566	10,540	68,393	0	68,393	272	68,665
9. Medical Director		0	0	3,300	3,300	0	3,300	0	3,300
10. Nursing & Medical Records		109,749	2,355	579	112,683	0	112,683	0	112,683
10a. Therapy		0	0	0	0	0	0	0	0
11. Activities		0	262	113	375	0	375	0	375
12. Social Services		18,276	37	1,733	20,046	0	20,046	0	20,046
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		128,025	2,654	5,725	136,404	0	136,404	0	136,404
17. Administrative		53,515	0	16,053	69,568	0	69,568	-16,053	53,515
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	9,949	9,949	0	9,949	2,140	12,089
20. Fees, Subscriptions & Promotion		0	0	828	828	0	828	131	959
21. Clerical & General Office		6,117	942	6,563	13,622	0	13,622	2,777	16,399
22. Employee Benefits & Payroll		0	0	36,894	36,894	0	36,894	3,350	40,244
23. Inservice Training & Education		0	0	0	0	0	0	109	109
24. Travel and Seminar		0	0	78	78	0	78	274	352
25. Other Admin. Staff Trans		0	0	2,381	2,381	0	2,381	257	2,638
26. Insurance-Prop.Liab.Malpractice		0	0	9,360	9,360	0	9,360	394	9,754
27. Other (specify)*		0	0	0	0	0	0	0	0
28. Total General Adminis		59,632	942	82,106	142,680	0	142,680	-6,621	136,059
29. Total General Administrative		216,944	32,162	98,371	347,477	0	347,477	-6,349	341,128
30. Depreciation		0	0	20,899	20,899	0	20,899	3,640	24,539
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	32,210	32,210	0	32,210	1,508	33,718
33. Real Estate		0	0	4,575	4,575	0	4,575	-35	4,540
34. Rent - Facility & Grounds		0	0	0	0	0	0	585	585
35. Rent - Equipment & Vehicles		0	0	0	0	0	0	89	89
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	57,684	57,684	0	57,684	5,787	63,471
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	0	0	0	0	0	0	0
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	30,061	30,061	0	30,061	0	30,061
43. Other (specify):*		0	0	328	328	0	328	-328	0
44. Total Special Cost Ce		0	0	30,389	30,389	0	30,389	-328	30,061
45. Grand Total		216,944	32,162	186,444	435,550	0	435,550	-890	434,660

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	10,716	10,716
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	82,089	82,089
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	16,991	16,991
7. Other Prepaid Expenses	390	390
8. Accounts Receivable-Owner/Related Party	116,121	116,121
9. Other (specify):	0	0
10. Total current assets	226,307	226,307
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	14,169	10,000
14. Buildings, at Historical Cost	600,118	608,365
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	48,226	48,226
17. Accumulated Depreciation (book methods)	-145,678	-148,637
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	516,835	517,954
25. Total Assets	743,142	744,261
CURRENT LIABILITIES		
26. Accounts Payable	35,879	35,879
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	54,387	54,387
30. Accrued Salaries Payable	8,483	8,483
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	4,540	4,540
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	12,458	12,458
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	115,747	115,747
LONG TERM LIABILITES		
39.Long-Term Notes Payable	10,479	10,479
40.Mortgage Payable	476,668	476,668
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	487,147	487,147
46.Total Liabilities	602,894	602,894
47.Total Equity	140,248	141,367
48.Total Liabilities and Equity	743,142	744,261

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	518,213
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	518,213
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	2,490
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,490
30. Total Revenue	520,703
31. General Services	68,393
32. Health Care	136,404
33. General Administration	142,680
34. Ownership	57,684
35. Special Cost Centers	328
35. Provider Participation Fee	30,061
37. Other	0
40. Total Expenses	435,550
41. Income Before Income Taxes	85,153
42. Income Taxes	0
43. Net Income or Loss for the Year	85,153

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Line 16 for mortgage insurance.